Department of Mental Health (DMH)
Mental Health Services Act (MHSA)
Community Services and Supports Component
Stakeholder Input Process

Workgroup: Small County Issues
March 16, 2005

Meeting Summary
For Discussion Only

1. Background

The Mental Health Services Act (MHSA) became state law on January 1, 2005. The passage of the Mental Health Services Act (MHSA) has created the expectation of a comprehensive planning process within the public mental health system. The multiple components of the Act are designed to support one another and lead to a transformed, culturally competent mental health system. This system must take into account the unique needs of small counties. Department of Mental Health (DMH) has learned over time that when guidelines, requirements and proposals are issued to "counties," the unique challenges of small counties and the communities they serve are often overlooked.

Prior to the March 1, 2005 conference call about the Small County Issues workgroup, DMH released "MHSA Implementation Issues for Small Counties," an issue paper which identified a number of challenges facing small counties in implementing the Community Services and Supports (CSS) DRAFT Requirements. The March 16, 2005 workgroup was formed to solicit feedback on the CSS DRAFT Requirements about small county implementation as well as on other components of MHSA as it moves forward.

Fifty-four (54) people attended the morning Client and Family Member (CFM) pre-meeting for both Small County Issues and Short-Term Strategies and 52 attended the afternoon workgroup session for Small County Issues.

Anticipated Outcomes

The anticipated outcomes of the workgroup meeting were:

1. To better understand and explore unique issues faced by small counties and their stakeholders.

2. To identify practical strategies that small counties might consider to make the values and vision of MHSA a reality in their communities.

3. To suggest specific changes in the CSS DRAFT Plan Requirements that will assist small counties in the implementation of the Mental Health Services Act.

2. Client and Family Member Pre-Meeting (9:30 – 11:30 am)

Fifty-four (54) people attended the morning Client and Family Member (CFM) pre-meeting for both Small County Issues and Short-Term Strategies. Simultaneous interpretation was available in American Sign Language (ASL).

Bobbie Wunsch, Pacific Health Consulting Group and facilitator of the MHSA stakeholder process, introduced the session by reminding people of upcoming dates for the MHSA stakeholder input, listed below. Ms. Wunsch introduced the two concurrent workgroup sessions, Small County Issues and Short-Term Strategies. The first part of the pre-meeting addressed common issues, including the review of the two agendas. Then participants divided into two smaller groups to ask questions and raise issues about the workgroup-specific agenda topics. By dividing into smaller groups, it was hoped that more individuals would be encouraged to add their voices to the discussion.

Ms. Wunsch thanked everyone who had provided feedback both at and following the last workgroup meeting concerning the role of pre-meetings in the MHSA stakeholder process and how the meetings could best be organized. She explained that a short survey would be distributed at the end of the CFM pre-meeting to solicit client and family member feedback about the purpose and format of future pre-meetings. Future meetings may be facilitated in part by clients and family members who may also help to set the agendas. Meeting formats would vary depending on the topic.

Schedule of Meetings

The DMH website is improving and changing every day. In the top left hand corner of the website is a new MHSA "Save the Date" link to the schedule and location of upcoming meetings and conference calls. (http://www.dmh.ca.gov/mhsa)

Upcoming workgroup and conference call dates are:

- Friday, March 18, 3-4 pm: Financing Conference Call
- Wednesday, March 23: Second meeting on the CSS DRAFT Requirements, covering Sections V-IX (except Section VIII). The pre-meeting will begin at 9:30 a.m. and the workgroups at 1 p.m. Participants should go directly to the 1 p.m. small discussion groups based on age (children and youth, transition age youth, adults and older adults).
- Wednesday, March 30: Third meeting in the series on CSS, covering financing, including Section VIII of the CSS DRAFT Budget Requirements. The pre-meeting will begin at 9:30 a.m. and the workgroup at 1 p.m.
- Tuesday, April 5 and Wednesday, April 6: Second general stakeholder meetings. These meetings will cover the same material and have been divided into north and south locations to make each meeting more accessible; participants should plan to attend only one of these meetings. There will be one combined summary of both meetings, as though it were one

meeting. The Los Angeles meeting will be held at the Burbank Hilton Hotel; while the Sacramento site has not been selected yet.

Review of Agenda

The Small County Issues Workgroup was designed to obtain feedback on two major issues: 1) the CSS DRAFT Requirements and how they can be adapted for small counties and 2) what flexibility DMH should incorporate as the entire MHSA planning proceeds to address the unique challenges of small counties. The core feedback DMH seeks is on flexibility required so that small counties and the communities they serve can implement the MHSA vision effectively.

Marilynn Bonin, DMH staff, then described the process for developing the issue paper for small counties. It was drafted by Carl Havener, a former small county mental health director, and Joyce Ott, a family member from Trinity County. This paper, posted on the website and available at the registration desk, should be seen as a jumping off place for discussion, not the authoritative "final word" on the topic.

Client and Family Member Comments and Questions

Client and family member participants had the opportunity to discuss the workgroup session purpose and anticipated outcomes, review the workgroup agenda, ask questions and provide feedback.

Basic Services Issues

- The document talks about giving small counties more time to fulfill requirements. They do not need more time; they need more money. If MHSA is about "business not as usual," then each county, regardless of size, needs a basic set of minimum staffing and services that could include a cultural competence office, consumer affairs/empowerment office, satellite offices, transportation and at least one client-run program. DMH should say, "Every county must" and put that in bold.
  - **DMH Response:** In terms of the timeframe issue: nothing prevents a county from going faster, but there are many obstacles.
- It would be helpful for DMH to create a list of the minimum services that every county must provide. Examples might include: address geographic issues (multiple sites throughout a large geographic area) and centralized self-help programs. There will always be county-specific issues, requiring case-by-case determinations.
- Someone has to take the heat for proposing funding levels, for saying how much it would really cost to provide the minimum services in a county. Small counties need more funding per capita than large counties, because there are few if any economies of scale.
- Our county would like to have a basic grant to immediately have the basic services. Time is less of an issue than funding.

Geographic/Size Issues

- In our large geographic area, there is only one mental health center. We have very little outreach because the distance is too far and transportation too hard.
- Our county is geographically huge with few people. The planning group intends to hire clients to conduct outreach to find those of us with unmet needs. This outreach needs to go beyond the Mental Health Board.
- County mental health service (CMHS) is the only mental health service available in the many small counties where there are no community-based organizations.
- Our county needs a mobile van that travels to the outer areas, to groups of people. It could be staffed with counselors, evaluators, etc. Our population centers are 40 miles apart, with three unserved populations. We could serve them better if we could go to them, rather than making them come to us.

Large Counties with Islands of Rural, Dispersed or Isolated Populations

DMH posed the following questions to the group:

MHSA basically says you need to give people what they need, not divided between small and large counties. It has been our observation that we write requirements for "counties" as a whole, but that small counties aren't in the same universe. We want to accommodate small county needs and need to know what flexibility they need. There are small county populations in large areas. There are also "urban" counties with large rural populations. How do you keep from diluting the needs of small county populations?

CFM Responses to DMH Question:

- It is difficult when you have small rural pockets in large counties vs. when you only have CMHS providing services. Counties with both urban and rural populations have dedicated planning staff and access to psychiatrists. In a small rural county, the director does planning, runs the programs and has to import psychiatrists from other counties. Small counties have unique needs from the other counties, even those with pockets of rural communities.
- Require that each county has baseline minimum set of services. Provide services based on isolated islands of services.
- Designate as communities rather than counties. For San Bernardino County, for example, differentiate between the urban centers and the islands of population.
- While acknowledging the differences in small counties, there has been no effort to convene the stakeholders in these counties prior to providing another draft to which we can respond. The language in the current draft is, at times, patronizing. The very idea of lumping together counties as small and implying there may be a single approach ignores the complexities of geography and cultural/ethnic realities. A small county near a metropolitan area does not have the same problems as those counties whose geography and population density categorize them as frontier.

Satellite Sites

- For small counties with large geographic areas, the best model for services is the WIC and Public Health collaboration, which uses outstationed clinics. Mental health services need staff to adopt this model, which could also enhance the creation of client communities. If, for instance, people knew that every other Wednesday, a mental health team would come to their

small community, people could take responsibility for moving toward self-help groups gathering together.

- We need satellite services in places where transportation is an insurmountable barrier. When you're in a state of confusion, the last thing you want to or should do is get in a car and drive over a mountain.
- Small counties need more sites in the corners of the county.
- The process for homeless people to obtain services from our agency creates too many barriers. First, the person in need must be referred by CMHS. The prospective client must be at the CMHS office by 7:30 a.m. to be one of only three people assessed in a day, a few days a week. This assumes the person can be organized to be there that early, is willing to go to CMHS at all, and can stand on line for several days before obtaining the service. Our service center would like an on-site CMHS staff to conduct these assessments and make referrals. Our agency only carries a caseload of 40 clients, because of this arduous referral process. In addition, there are limited services and supports for us to refer them, for example, only one hotel. Our hands are tied.

Age Group Issues

Children and Youth

- Transportation is a huge problem for families. Parents need to take time off work to get their kids to services and can miss hours of work for a short appointment.
- Healthy Families does not provide adequate mental health services.
- To obtain mental health services as a Medi-Cal beneficiary, one needs full-scope Medi-Cal. This means parents cannot have a car or look for work and maintain benefits for their children.
- Children without Medi-Cal or who do not meet the criteria of SED or SMI are often unable to get services. If CMHS is the only mental health service in a county, large numbers of children are unserved.
- Parents of children with SED need respite, support and services that help their children stay at home, not more institutional beds. Children should not have to fail first.
- There are no hospitalization placements for children in most small counties.
- Early intervention should be higher on the MHSA implementation priority list: When children are treated before they start really having problems, the financial and emotion costs are significantly lower and the chance of avoiding serious problems later is higher.
- Use the schools. School mental health services are lacking and yet, schools are ideal places for programs and for early intervention. Schools often serve as community centers or could often become so more efficiently than other sites. Schools have lower enrollment than in years past, and therefore have space for other programs. Their current focus on school readiness makes them a good match as well.
- While there are lots of plusses about locating services at schools, stigma is still so profound that those students will be teased mercilessly.
- Stigma is a very real problem particularly in small counties.

Transition Age Youth

- Early intervention works well for younger children, but it is more difficult to persuade transition age youth to use services. Counties need to develop community partnerships with community health centers and others because transition age youth might be more likely to

use a satellite center that wasn't identified as a mental health center. Counties need to target outreach and services to transition age youth.
- Our county has one adult and one children's psychiatrist and no programs for teens with mental health or substance abuse.

Older Adults
- Seniors in our county are underserved. The CMHS clinic does not take Medicare.
- Our geriatric population is beginning to outgrow the younger population and we underserve them. If they get dementia, even if they have been schizophrenic for 50 years, CMHS does not want to deal with them.

Crisis Issues
- Our county has two beds for suicide, etc.
- A police car has taken people in crisis to another county; now they use an ambulance.
- Has anyone looked at the cost/benefit analysis of providing crisis services on-site versus shipping people out of county?
- Our county spent $3,500 to take people in crisis to another county.
- Siskiyou County has a innovative program with data to support it with a walk-in center for crises. Counties should take walk-ins. You cannot tell if someone is in crisis by looking at them: walk-in centers would help.
- NAMI supports walk-in centers as well as the need for more beds.

Enrollment Issues
- "Enrollee" came directly from AB 2034.
- AB 2034 uses terms like "voluntary" enrollment, not mandatory.
- Enrollee-based services do not make sense for early intervention.
- There is no substitute to enrollment for evaluation purposes. There must be outcomes that can be documented. Look at Ohio's rubric. Get academic help to develop a survey that asks basic questions about empowerment, hope, independent living, etc. If DMH develops a tool quickly, counties could get it out to clients to show what works. There should be a benchmark of people who are involved in the program.
- We want it to be as easy as possible for people to receive the care they need. Putting up additional barriers such as enrollment is problematic.
    - **DMH Response.** The use of the term "enrollee" or "member" remains a controversial point. However, DMH sees it as an opportunity. The only area of growth in the state or county budgets is in MHSA. We need to have a group of people we identify, serve, follow and evaluate. It is fundamental to make sure that MHSA funds reach the populations mentioned in MHSA.

Peer Programs
- When clients have access to client-run centers, they do not have to be evaluated and diagnosed to obtain services, they are able to get referrals and services and get on the road to wellness, not remain stuck on the path of illness.
- Our county has a new consumer group that would like to have a drop-in center.

- Most people getting services in our county see a therapist once every six weeks, which is inadequate. A peer program would be more cost-effective than hiring psychiatrists.
- Anecdotally, advocates have seen that providing services before the crisis works better and prevents hospitalization. Advocates have collected data across the state to show that peer services are more cost-effective and helpful, and have successfully used these data to educate Boards of Supervisors.
- Our county needs peer-to-peer outreach programs to visit the community more as well as more board and care facilities. There is peer counseling at CMHS and consumers are working on a drop-in center.

Suicide Issues

- Our county had 25 suicides this year. Only five of them were clients involved in mental health system prior to the time of their suicide. How can we address that?
- Education about mental health is needed for everyone. The money saved on later services would be large. Rural counties have the highest suicide rates and education would help reduce them.
- Two years ago, Amador County had the highest youth suicide rate in the state. The county established a program that uses peers and "yellow ribbon" cards that cut the rate by 75% in one year. But there was no way to share this model program with others in the state.

Funding Issues

- Where are we in the process regarding a discussion of allocation of funds?
  - **DMH Response:** A number of proposals are under consideration, some currently being reviewed by state attorneys. There will be a conference call on Friday, March 18 on financing, in preparation for the Financing Workgroup meeting on March 30. The allocation of planning money did not set a precedent for how to allocate the rest of the MHSA funding. The planning money was allocated so that the counties could quickly begin their processes. The rest of the funding is being considered carefully.
- What happened that you already need attorneys?
  - **DMH Response:** Every time a state department releases a proposal of this magnitude, attorneys review the proposal carefully. This is standard practice.
- Small counties tend to have a higher per capita prevalence of mental illness and number of people involved in the county mental health system than larger counties. Will the funding take into account this higher per capita need compared to the overall size of the population? Also, some counties have significant services to offer mental health clients. Should those get more money because they are a magnet?
  - **DMH Response:** DMH has not determined funding allocations yet. The prevalence rates are derived from the number of people with specific characteristics one would expect to see in a given population; in this case, studies have estimated how many cases of specific illnesses are found in a population. However, we do not know if these prevalence rates are aggravated by living in a small area, or by living under the stress of urban life.

Psychiatrist Issues

- What do you do when you have nothing? Our county has two part-time psychiatrists who drive 75 miles from another county to evaluate patients on medications.

- In small counties, clients have very little choice. Our county has one psychiatrist who comes from another county. Not everyone gets along with him and they do not have a choice of another provider. If they do not want to see him, they have to use their treating physician, who may not be trained in mental health issues.

Other Issues

- To be eligible for services, a person must fit in all the right boxes . The working poor who are ineligible for Medi-Cal are particularly underserved.
- Even though we have a high unemployment rate, we have no homeless center, no halfway houses.
- The early intervention and prevention component of MHSA is being delayed. Instead, it needs to have more money and start earlier in the planning process.
- Consumers who get jobs working in peer programs risk losing their Medi-Cal and Social Security and thereby being unable to afford their medications.
- When discharge planners from psychiatric hospitals send referrals to skilled nursing facilities in our county, those referrals are thrown in the shredder. This population needs more funding for post-discharge services.
- Look at generic places such WIC, Planned Parenthood, acupuncture, other alternative healers, etc. who are already meeting some of the unmet need to learn from them.
- A rural county in Colorado has a best practice worth noting: they have no symptoms barrier or threshold to get services.
- It would be great to have all these innovative ideas available to counties during the planning process, but each county needs to make its own plan for what is best for its community.
- Our county is struggling over how to define "target population." For example, can the homeless population be segmented or must the whole homeless population be served?
- Maybe Meals on Wheels programs can give tips on who needs to be served.
- Lower income people often move to rural areas for lower cost of living. The resources are smaller. Their natural supports are lost and it is difficult to help them.
- Some people come to rural areas to get away from stigma found in large urban areas and to get away from the large urban areas.
- Have the Mental Health Board and a "few" small county clients come together to identify basic necessities lacking in all small counties first.

3. Workgroup on Small County Issues (1:00 – 4:00 p.m.)

Fifty-two (52) stakeholders participated in the workgroup session on Small County Issues on March 16, 2005, from 1:00 – 4:00 p.m.

Lisa Canin, Pacific Health Consulting Group, welcomed participants and introduced state staff. She invited at least one DMH staff person to be present at each table. She then introduced the work for the meeting which focused on providing two types of feedback to the state: 1) small county accommodations that should be included in the Community Services and Support (CSS) Draft Requirements document and 2) recommendations about flexibility needed by small counties in future MHSA implementation discussions. Additional copies of the CSS DRAFT

Requirements were distributed as were forms to record comments made during the small group discussions. Each table was assigned one of the first six sections of the CSS DRAFT Requirements to review in terms of the implications for small counties.

After the groups at each table did their work, they reported back to the entire group, and others were asked to add their own thoughts on each section. For this first task, the review of the draft requirements, the group as a whole was asked to identify the level of support for suggested accommodations. Comments with a high level of consensus, as demonstrated by a show of hands, are followed by a note in parentheses: *(High)*.

What accommodations should be added to each of the first six sections of the CSS DRAFT Plan Requirements for small counties?

Section I – Public Planning Process

- Clarify requirements for small counties, recognizing resource restrictions. Acknowledge explicitly small counties' lack of resources and lack of funds (for transportation, for example) to meet all the specific requirements of the plan reaching all the discrete ages. A small county may not have a large group of transition age youth or seniors. Allow small counties to meet requirements across the age ranges. *(High)*
- With the prospect of not getting much money, both from MHSA in general and for small counties in particular, advocates are trying to involve people from all over the county. DMH and the counties may not be able to deliver on the raised expectations. Together, everyone working on MHSA at the state and local levels may be getting people excited about being involved for once, but MHSA is not going to meet those expectations. *(High)*
- Section I seems to be CMHS-driven, not community-driven. It needs to be community-driven.
- Clarify the target population to direct outreach to: is it people already in the mental health system or others?
- Appendix A: it contains nothing about assessing self-help programs. Since the heart of the MHSA effort is to grow the community to work toward healing, self-help programs are critical. Add questions such as, "Do you have the self-help groups, what do they need?"
- Distribution of funds for planning may not allow sufficient outreach.
- Specificity in requirements may be unrealistic for small counties: there are too many variables to report on.
- It is hard to identify one person with responsibility for the entire plan. Small counties need flexibility on this requirement.
- Change the word "train" to "educate." Clarify what is meant by the word "training"; counties cannot train before they begin their plan.
- Incorporate language about aggressive outreach.
- We have to do the planning process right.

Section II – Identifying Community Issues Resulting from Untreated Mental Illness

- System capacity: in a small county, it is difficult to purchase enrollee-based services. The whole concept is predicated on the idea that there are third party services the county can rely on, but in small counties, these supports do not exist. Change the ratio for small counties or let the county develop their own ratio or vary the enrollee-based ratio by service. The plan should be community-driven, but the more things DMH requires, the fewer aspects the community can decide on. *(High)*
- Flexibility across the age groups: small counties can not address every age group. Give some flexibility about focusing on the most needy in the community.
- While small counties are often more able to work with other agencies and can convene easily, one group or person or incident can overwhelm the status quo, giving a skewed vision of what happens. Consumer input, across the full spectrum of potential consumers, is critical.
- Lack of infrastructure makes decisions difficult.
- The enrollee-based program in the Children's System of Care (CSOC) forced us into a box at evaluation time. It looked like our county served few people. When it comes time to account for the money, small counties will have to show more than a tiny number of people served.
- Broaden definition of who can be served: many children who are not eligible for Medi-Cal or EPSDT, whose parents work, cannot obtain services. Other parents are unable to go to work for fear of losing their family's Medi-Cal.
- With only 5% for early intervention and prevention, we remain a "fail first" system.
- How do we decide who to serve? Although the most underserved in our county are transition age youth and older adults, it is likely that more money will go to CSOC or adults. Counties need to be careful about how to allocate funds.
- There is no CSOC really.

Section III – Analyzing Mental Health Needs in the Community

- DRAFT Requirements got it right for flexibility: let counties do as they can to meet the individual needs. *(High)*
- There needs to be a baseline of staffing, infrastructure, IT and aggressive outreach. *(High)*
- Small counties need more money to do the same work as larger counties. It takes more staff time to do some work. Small counties need more staff per capita to reach the corners of their county while large counties have economies of scale. Small counties have same administrative and service requirements, but fewer people to meet them. *(High)*
- There needs to be standardization across the counties. While small counties do not have the resources to meet the same requirements as large counties, it will still be important to be able to draw a statewide picture. It will be valuable to be able to say each county fulfilled some of the requirements based on their ability, so that now DMH and local communities know about unmet needs, who is inappropriately served and underserved.
- Transform the system by helping the unserved and underserved to get services.
- Evaluation: create a measuring tool for the voters to see what DMH and local communities did with the money. With CSOC, communities needed to change the system but didn't have

the numbers. We need evaluation from the consumers and family members about whether they note changes in their quality of life such as , more friends, recreation, etc.
- Counties should not compete for money.
- Our county may not be able to see the possibilities and vision of MHSA.
- 24/7 coverage is a big concern for small counties.
- Maximize funding to small counties to carry out the recommendations of this section.
- Compare county responses to a state standard.

Section IV – Identifying Focal Populations for Enrollment

- In this section, it appears everything flows in and out of the county system. Be aware that not everyone wants to be part of that system. The section also does not speak to community partnerships, especially with self-help groups. *(High)*
- Small counties need more flexibility in defining who is unserved and underserved. Geographically isolated adults and children have more challenges than just their physical location. *(High)*
- Enrollment is a problem: Many clients and family members do not want to do it. There are other ways to justify how the money was spent and the number of clients served. *(High)*
- There should be other ways besides enrollment to track how effectively the money is spent, based on how the community decides things should be done.
    - **DMH response**. DMH uses this language because the language is in MHSA, because these words were in AB 2034. What MHSA says is "take a model that works and do more of it." The other aspect of enrollment is that is protects communities from encroachment from everyone wanting the money for their own worthy individual idea. The Act says that counties are responsible for these enrollees. If the funding is linked to enrollment, it is more protected.
- Page 16: availability of personal services coordinators, case managers. Most small counties barely have 24 hour crisis response. DMH cannot expect county employees to be available 24/7.
- Chart on Page 17: revise. Overarching categories should be geographic, cultural/linguistic and other, with the age groups under these categories. This is particularly important for small counties, but can be used for all counties. Delete numbers enrolled, but monitor over time.
- Transition age needs to include transition age older adults (before 65).
- The same group who is not able to obtain services now will still not get services because they do not fit into the right eligibility box.

Section V – Identifying Strategies for System Capacity Changes

Capacity Issues

- These strategies raise expectations of clients, given there is going to be too little money to effect major change, especially transition age youth who are transitioning out of the system. *(High)*
- The requirements are also too prescriptive; there is not enough flexibility. Small counties would need more money to implement what is required. *(High)*

- Section V is the most powerful section of the CSS DRAFT document. Some strategies are extremely prescriptive. Throughout Section V, DMH has expressed support for some programs by "brand name" when use of concepts would be better. *(High).* For example:
    - Under wellness and recovery plans, there are many other self-directed plans. It should not be so limited.
    - Under Assertive Community Treatment (ACT or sometimes PACT) this program came out of the East Coast, is very prescriptive, can be restrictive and can be negative to client outcomes.
- Add peers to wraparound teams list; there is nothing more comforting than having a peer there in a crisis.
- Add telemedicine.
- Every county should be brought up to par with minimum legal/moral needs of Prop. 63 before implementing county customized desires.
- There is concern about the expectation of Board of Supervisors versus requirements: how can counties strengthen the level of accountability?
- Provide more technical assistance.
- Appendix C and D are so poorly written that certified professional staff have trouble responding. The uniform response of other stakeholders, including those at a homeless shelters, is that it is professional gibberish.

Involuntary Services

- Counties will alienate the very people they are trying to serve if they fund involuntary care with MHSA. *(High)*
- Involuntary services is a big issue. The statement in which the expansion of them is mentioned as a potential use of MHSA funds is detrimental. The coalition that wrote the Act came together with the understanding that the money would not be used for involuntary services, but rather for healing and empowerment. This language raises feelings of hopelessness. There is already money for the old ways. MHSA is for new services. Involuntary services will tear us apart, county to county.
- Without involuntary services, how do you get services for the people who do not think they have mental illness? Sometimes after they do get services, they are thankful.
- Mental health already has money for involuntary services. MHSA is specific to a voluntary, recovery model. No one is dragged in for care. We all understand that involuntary care is essential. We already have it. Using MHSA for it would be supplantation.

Section VI – Assessing Capacity

- Use clear definitions of roles and position. Some terms are used in multiple contexts; for example, "supportive services" can refer to administrative assistance for the county as well as a particular kind of support services for clients. *(High)*
- Broaden types of staff who can be added: consumers, family, other types of healers, community services.
- Provide special funding for management to complete the capacity assessment process in small counties, where management wears many hats. It is labor intensive to complete the various stages.

- Create a small county version of the CSS Plan itself .

Looking ahead to other MHSA components, in what ways can the State acknowledge the flexibility needed by small counties?

Staffing

- Small counties need more staff because of long distances to assess unmet needs and to give or receive services.
- Small counties are driven by crisis services because of fewer staff and services.
- Have a continuum of staff for IMD and board and care facilities, including psychiatrists, etc. Provide resources to draw staff into the counties.
- Telemedicine will add flexibility, especially with requirements about where you can and cannot use it.
- Train primary health care providers specifically in small counties because they are providing treatment for mental health issues that they do not really understand.
- Address issues related to lack of psychiatric resources, especially for children.

Focal Populations

- Be aware of demographics: county mental health services are serving more people per capita, often because they are the only services available.
- Aging populations are increasing.
- Expand cultural competency beyond language and ethnicity: consider rural culture, grandparents raising grandchildren, drug culture and client culture.
- Include gay, lesbian, bisexual and transgender people in cultural competence.
- Counties with existing services for the focal groups are being consumed by demand.

Funding Issues

- Small counties need more money and staff because of geographic distances and small pockets of population.
- Do not use a population density or population formula. These are inaccurate ways to allocate for needs of small counties and penalizes them.
- Identify programs that can be funded with MHSA funds.
- In the introduction for MHSA, note that one cannot take the wellness and recovery model and compare it to the medical model. There are three types of funding: two can be transforming, and Medi-Cal is “same old same old.” The MHSA money will just be a blip, unless we set baselines and support principles and hold every county accountable to those service and staffing baselines. The budget is the real vision document. It says what is valued.

Client-Driven Focus

- Provide models or templates for self-help groups.
- Focus more on client community-based, client-centered approaches; lots of people viewed the CSS DRAFT document as being planner-focused, not client-focused.
- Offer leeway with credentials, which will help with client-centered approach.
- Have more client-run services.

Support Services

- Housing is really a problem, especially with Board and Care Homes: these reimbursement rates have not raised in years. This is especially hard for small counties. It is an important part of the system. Anything that the state can do would help.
- How can we use our funds locally to help with housing? Counties need flexibility for setting people up in apartments. New York City has a rich program for this, with a high success rate.
- Encourage counties to identify model programs, such as mental health court.
- Fund satellite services in small communities.

Community Issues

- Encourage cross-county and cross-agency collaboration.
- Expand beyond county focus to assess community needs: who else is serving the community and what do they need?
- Add questions about how many community-based organizations there are in the community meeting mental health needs.

Flexibility

- Provide flexibility on enrollee-based services.
- Provide flexibility on 24/7 response.
- Provide flexibility on addressing needs of four age groups.

Other Issues

- Early intervention should be rolled out earlier and with more funding.
- DMH must be responsible for holding counties accountable.
- Keep the principles of Olmstead Supreme Court Decision in mind.

Q. When will the County plans be reviewed?

A. Some plans were submitted February 15, some March 15. They are currently being reviewed and discussed with counties.

Q. Will they be public?

A. DMH will make county plans available once they are final. Stakeholders wishing to view a county plan before the state has approved it should contact the county and request a copy of the draft plan.